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# A Coroner System in Crisis: The Scandals and Struggles Plaguing Louisiana Death Investigation

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# A Coroner System in Crisis: The Scandals and Struggles Plaguing Louisiana Death Investigation

## I. INTRODUCTION

### A. “The CSI Effect”<sup>1</sup> and Public Misconceptions Regarding Louisiana Death Investigations

In today’s world of highly glamorized forensic science dramas, such as CSI, the public has developed grave misconceptions about what realistically can be accomplished and what is statutorily required in the performance of a forensic death investigation.<sup>2</sup> Though many Americans are led to believe the world of death investigation is filled with highly educated professionals using cutting edge investigative techniques in order to quickly solve crime, many death investigations are limited in their scope and effectiveness by outdated laws, insufficient regulation, and poor funding.<sup>3</sup> In the real world, death investigations are time consuming and resource draining, often only providing probable or likely scenarios rather than hard and fast answers about what actually occurred.<sup>4</sup>

A distinct problem facing death investigations throughout the United States derives from both the laws that qualify those who may perform death investigations and the great discretion the laws give to these officers.<sup>5</sup> Many officers have no specialized medical or legal training, and death investigation offices commonly lack higher government supervision and regulation.<sup>6</sup> Because

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1. Jeffrey Toobin, *The CSI Effect: The Truth About Forensic Science*, THE NEW YORKER, May 7, 2007, [http://www.newyorker.com/reporting/2007/05/07/070507fa\\_fact\\_toobin](http://www.newyorker.com/reporting/2007/05/07/070507fa_fact_toobin).

2. *Id.* Much of the information provided in the following material has been obtained by this author as a result of undergraduate and professional training in forensic investigation. This author has attended the Medicolegal Death Investigator’s Training Course which is put on by the Saint Louis University School of Medicine, and prior to law school, worked in the Louisiana coroner system as a medicolegal investigator.

3. See generally Andrea R. Tischler, *Speaking For the Dead: A Call for Nationwide Coroner Reform*, 33 SW. U. L. REV. 553 (2004); Toobin, *supra* note 1.

4. *Id.*; Toobin, *supra* note 1.

5. Tischler, *supra* note 3.

6. See generally LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573 (2002). See also Paul C. Giannelli, *The Abuse of Scientific Evidence In Criminal Cases: The Need for Independent Crime Laboratories*, 4 VA. J. SOC. POL’Y & L. 439 (1997) (compiling a collection of incidents and

evidentiary findings by death investigators can be crucial to the outcome of both criminal and civil cases, mistakes and wrongdoings at the hands of death investigators can lead to great injustices.<sup>7</sup> Whether a mistake leads to the wrongful conviction of the innocent, allows the guilty to go free, or allows an unjust award of damages, the ramifications of an ineptly governed death investigation system are felt throughout the entire justice system.<sup>8</sup>

### *B. The Louisiana System Has Many Problems*

In Louisiana, death investigations are governed by the statutes that regulate the Louisiana coroner system.<sup>9</sup> This statutory scheme gives coroners great discretion in the scope and performance of death investigations. At the same time, however, it does little to ensure that coroners are qualified to make the decisions they are statutorily required to make.

While the statutes governing the Louisiana coroner system create ample opportunity for costly mistakes, this is far from the only problem facing the system. Because coroners, as elected officials, are independent state officers, they go largely unsupervised by higher governmental enforcement bodies.<sup>10</sup> This lack of supervision, coupled with a deficient and outdated statutory scheme, creates additional opportunity for mistakes and improper practices.<sup>11</sup> Recently, this overarching lack of supervision over Louisiana coroners made headlines when the practices of Dr. George McCormick were exposed.<sup>12</sup>

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scandals discovered throughout the United States due at least in part to a lack of supervision of forensic scientists).

7. Tischler, *supra* note 3.

8. *Id.*

9. See LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106 (2003).

10. LA. CONST. art. V, § 29; Mullins v. State, 387 So. 2d 1151 (1980).

11. See LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106.

12. *Statements Allege Fmr. Coroner Did Not Perform Autopsies* (KSLA News 12 (Shreveport) television broadcast), <http://www.ksla.com/Global/story.asp?S=4781385> [hereinafter *Statements*].

*C. The McCormick Scandal*<sup>13</sup>

In the fall of 2005, shortly after Hurricane Katrina, Dr. George McCormick, the longtime Caddo Parish Coroner, died unexpectedly from a massive heart attack.<sup>14</sup> For years, many parishes in North Louisiana, including Caddo Parish, had contracted with Dr. McCormick's private autopsy business, Forensic Pathology, Inc., to perform a majority of their forensic autopsies.<sup>15</sup> Shortly after the death of McCormick, news began to break of alleged scandals involving the McCormick office and his private autopsy business.<sup>16</sup> Soon thereafter, investigators learned that longtime McCormick investigator (and employee of his private autopsy business), Lisa Hayes, forged Dr. McCormick's signature on certain documents purporting to name Hayes as the coroner of Caddo Parish in the event of McCormick's death.<sup>17</sup>

In the spring of 2006, more serious allegations regarding the practices of Forensic Pathology, Inc. began to make headlines.<sup>18</sup> Because she was granted immunity from prosecution, Lisa Hayes agreed to testify fully as to the practices employed by McCormick's office during the performance of autopsies.<sup>19</sup> Hayes has since testified that in approximately 80% of the autopsies performed over what was approximately a seven year period by McCormick's business, she fully performed autopsies without the presence or supervision of McCormick.<sup>20</sup> Hayes, who was not a physician, performed external examinations of bodies, photographed the bodies, removed clothes and evidence, and then fully eviscerated the bodies.<sup>21</sup> She tracked bullet paths, measured gunshot wounds, and removed bullets from bodies in homicide cases, often without any supervision from McCormick

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13. See Testimony of Record, *State v. Beaner*, No. 225,720 (1st Jud. Dist. Ct. Apr. 18, 2006), available at <http://lapda.org/PDF%20Files/04.18.06.Transcript.pdf> (testimony of Lisa Hayes) [hereinafter Hayes Testimony]. See also *Statements*, *supra* note 12.

14. Hayes Testimony, *supra* note 13; LA. ASS'N OF CRIM. DEF. LAWYERS, INVESTIGATION OF THE CADDO PARISH CORONER'S OFFICE AND DR. GEORGE MCCORMICK, <http://www.lacdl.org/McCormickInvestigation.cfm> [hereinafter LACDL].

15. Hayes Testimony, *supra* note 13; LACDL, *supra* note 14; Vickie Welborne, *Commission Works Toward Construction of Crime Lab*, THE TIMES (Shreveport, La.), June 23, 2006, at 1A.

16. Hayes Testimony, *supra* note 13; *Statements*, *supra* note 12.

17. *Statements*, *supra* note 12.

18. Hayes Testimony, *supra* note 13; *Statements*, *supra* note 12.

19. Hayes Testimony, *supra* note 13, at 6–12.

20. *Id.* at 16, 20–21.

21. *Id.* at 19–21, 41.

whatsoever.<sup>22</sup> Hayes also admitted to forging McCormick's signature on numerous death certificates as well as writing McCormick's initials when sealing evidence containers.<sup>23</sup>

On a usual day, McCormick would come into the office around 5:00 p.m., take notes from what Hayes gathered during her performance of the autopsy, and then, at a later time, he would compose his autopsy report based on her notes.<sup>24</sup> McCormick would subsequently testify to the findings of the autopsies under oath, asserting that these findings were based on autopsies performed by him, therefore perjuring himself numerous times.<sup>25</sup> These practices continued until Dr. McCormick's death on September 20, 2005.<sup>26</sup>

Since the discovery of the improper procedures employed by McCormick's office, numerous motions have been made by defense attorneys. As the investigation into the practices and procedures employed by McCormick is still ongoing today, homicide convictions and other cases that included testimony and evidence based upon the findings of McCormick's office will continue to be challenged.<sup>27</sup>

#### *D. The Time for Reform is Now*

The lack of supervision that allowed the McCormick scandal to occur is disturbing—especially when one considers that Dr. McCormick was a forensic pathologist with years of pathology training.<sup>28</sup> When one imagines what could occur in the offices of certain coroners that have no training in pathology, this lack of supervision becomes even more frightening.<sup>29</sup> All this, combined with Louisiana's statutory scheme that gives coroners great discretion in how to handle death investigations, makes one realize that Louisiana's death investigation system is ripe with opportunity for impropriety, mistakes, and the occurrence of further injustices.

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22. *Id.*

23. *Id.* at 27–30.

24. *Id.* at 69. Hayes even testified that there were a few occasions where McCormick never showed up and the bodies that had been autopsied were released to the funeral home, never having been viewed by McCormick. *Id.* at 76.

25. *Id.* at 20–21.

26. LACDL, *supra* note 14.

27. See Hayes Testimony, *supra* note 13; LACDL, *supra* note 14.

28. See Hayes Testimony, *supra* note 13. Forensic pathologists, in theory, have more specialized forensic training than other pathologists and physicians; therefore making the actions of McCormick, who was a forensic pathologist, even more alarming. *Id.*

29. See, e.g., LA. REV. STAT. ANN. §§ 33:1551–1573 (2002); LA. CODE CRIM. PROC. ANN. arts. 101–106 (2003).

This Comment analyzes the problems with Louisiana's coroner system, beginning with Part II, which looks at the history and evolution of death investigation and how it has influenced Louisiana law. Part III of this Comment examines the laws that establish and govern the Louisiana coroner system, looking carefully at where the coroner's office fits within our legislative scheme and what the role of the coroner entails during death investigations. Part IV of this Comment analyzes specific problems that arise from the current laws governing the coroner system. Part V compares Louisiana death investigation laws with those of other jurisdictions. Finally, Part VI proposes suggestions to improve the Louisiana death investigation system.

## II. BACKGROUND

Forensic death investigation of the human body is generally referred to today as medicolegal death investigation.<sup>30</sup> Medicolegal death investigation combines medicine and law in order to ascertain the relevant facts that lead to determinations of the cause and manner of death.<sup>31</sup> Investigative techniques combining the likes of law and medicine have been around for thousands of years.<sup>32</sup> Although similar approaches to death investigation have been seen worldwide throughout history, none has had more of an impact on the current United States and Louisiana death investigation systems than the English coroner system.<sup>33</sup>

The coroner system, as it is known today, was established by the English kings during the middle ages.<sup>34</sup> Originally, coroners were called "crowners."<sup>35</sup> Crowners were knights appointed by the king of England to investigate deaths in which the crown had a

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30. See generally JEFFREY M. JENTZEN ET AL., *MEDICOLEGAL DEATH INVESTIGATOR: A SYSTEMATIC TRAINING PROGRAM FOR THE PROFESSIONAL DEATH INVESTIGATOR* (1996). See also Cyril H. Wecht, *Legal Medicine and Forensic Science: Parameters of Utilization in Criminal Cases*, 34 DUQ. L. REV. 797, 798-99 (1996).

31. See generally JENTZEN, *supra* note 30. See also Wecht, *supra* note 30.

32. Wecht, *supra* note 30, at 798-802. Ancient historical accounts contain references to crude forms of medicolegal investigation. *Id.* Forensic investigators in Rome reportedly examined the body of Julius Caesar in an attempt to ascertain which stab wound caused his death. *Id.* A section of the Code of Justinian specifically discusses the need to combine law and medicine to deal with social problems. *Id.* Evidence of the use of ancient medicolegal techniques have also been seen throughout the Middle East, Africa, and Asia. *Id.*

33. *Id.* at 799.

34. *Id.* at 799-800.

35. *Id.*

property interest.<sup>36</sup> When the death of someone in the kingdom occurred, the kings saw this as an opportunity to acquire property.<sup>37</sup> Therefore, kings charged the crowners with the duty of investigating the facts surrounding accidental, suspicious, and unexplained deaths in order to determine what property may have contributed to the death or could be seized as a result of the death.<sup>38</sup> Based on the investigations of the crowner, together with locals who supplied and reviewed important factual information, a ruling would be made on whether property would be seized and given to the king.<sup>39</sup> The purpose of the early English coroner system therefore was not to apply science in order to make detailed medical determinations about the cause and manner of death.<sup>40</sup> However, because the crowners used crude medical and legal knowledge to make fact based determinations regarding questioned deaths, they were, in a sense, death investigation experts.<sup>41</sup>

As time progressed, crowners came to be called coroners.<sup>42</sup> Coroners began to be elected in different counties and after elected would serve life terms.<sup>43</sup> Because they wielded the power to seize property from citizens, many coroners began using their power for self-serving interests.<sup>44</sup> As coroners came to be elected rather than appointed, the knights who specialized in death investigation were replaced by powerful political figures with little to no expertise in the field.<sup>45</sup> It was this system, one based on political interests in property rather than science, which crossed the Atlantic Ocean and thereafter influenced death investigations in the American colonies.<sup>46</sup>

After the English coroner system was transplanted to America, the evolution of death investigation occurred at a rapid pace in Europe.<sup>47</sup> Scandals and political problems caused England to begin the process of revamping and reforming their coroner system.<sup>48</sup>

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36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

43. Tischler, *supra* note 3, at 555.

44. Wecht, *supra* note 30, at 800.

45. *See id.*; Tischler, *supra* note 3, at 555.

46. Wecht, *supra* note 30, at 800.

47. *Id.*

48. *Deadly Conflicts: Conflicts of Interest in Death Investigation Systems*, FUNERALETHICS.ORG, <http://funeralethics.org/coroners.htm> [hereinafter *Deadly Conflicts*].

In the United States, however, the death investigation system was developed based on the influence of the old English coroner system.<sup>49</sup> Early coroners in the United States were elected rather than appointed.<sup>50</sup> Many states required little to no educational background in order to hold the office, as both non-pathologists and non-physicians were allowed to be elected as coroners.<sup>51</sup>

In the wake of several scandals, the first major reforms to the United States coroner system occurred.<sup>52</sup> The late 1800s and early 1900s saw the creation of the first medical examiner systems—death investigation systems where the chief officer is appointed rather than elected and is usually required to be a forensic pathologist.<sup>53</sup> Although social demands in the twentieth century caused many states to adopt either medical examiner systems or to establish more competent coroner systems, death investigation in Louisiana remained relatively unchanged.<sup>54</sup>

The current United States death investigation system varies greatly from state to state.<sup>55</sup> Some states still have coroner systems, some have medical examiner systems, and others have hybrid systems that combine features of both.<sup>56</sup> This lack of uniformity has inspired multiple efforts to develop competency standards for death investigations.<sup>57</sup> Although different forensic organizations have endorsed similar standards, the laws that govern death investigation still vary greatly between the states.<sup>58</sup> While some states require that a board certified forensic pathologist be the chief investigative officer of a county office or pathology facility, other states require no more than a high school education in order to hold the office of coroner.<sup>59</sup> Not surprisingly, the Louisiana coroner system has a statutory scheme uniquely its own.<sup>60</sup>

The failure to update and reform statutes regulating the actions of Louisiana coroners has resulted in the current Louisiana coroner system being both outdated and poorly governed. If Louisiana death investigation is to evolve to meet the competency standards

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49. Wecht, *supra* note 30, at 800.

50. *Deadly Conflicts*, *supra* note 48.

51. *Id.* See also Tischler, *supra* note 3, at 556.

52. Wecht, *supra* note 30, at 801.

53. *Id.*

54. LA. CONST. art. V, § 29; Wecht, *supra* note 30, at 801–02.

55. Tischler, *supra* note 3, at 557.

56. *Id.*

57. *Id.*

58. *Id.* at 556–57.

59. *Id.* at 556–59.

60. See LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573 (2002); LA. CODE CRIM. PROC. ANN. arts. 101–106 (2003).



necessary to protect against injustice and prevent further scandals, major reforms to the current law must be made.

### III. ANALYSIS

#### *A. Current Structure of the Louisiana Coroner System*

The Louisiana coroner has a vastly important role in Louisiana death investigations.<sup>61</sup> Although forensic investigators are not able to perform the "miraculous" investigative techniques often seen on television, the performance of thorough death investigations is vitally important to the public welfare.<sup>62</sup> Negligent or incompetent investigations by the coroners and their agents can lead to homicides going undiscovered, wrongful imprisonment, improper diagnosis of fatal communicable diseases, and the provision of inaccurate answers to families and courts.<sup>63</sup> Because the human body is widely regarded as the most valuable and important piece of evidence in any death investigation, it is crucial that medicolegal investigations by the coroner are performed effectively and competently by qualified professionals from the time of initial investigation at the scene through completion of the autopsy and autopsy report.<sup>64</sup>

To fully grasp the importance of the office of the coroner in Louisiana, one must understand: (1) where the office of the coroner fits in our state governmental structure; (2) the coroner's role in the performance of death investigations, mental health

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61. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551-1573; LA. CODE CRIM. PROC. ANN. arts. 101-106.

62. For a discussion of the importance of death investigators, see generally Tischler, *supra* note 3 and Toobin, *supra* note 1.

63. For a collection of stories involving investigation mistakes and improper practices, see generally Giannelli, *supra* note 6. See also Wecht, *supra* note 30, at 801-11.

64. For a discussion of the importance of thorough death investigation, see generally Tischler, *supra* note 3. To illustrate this, imagine if the body of a young woman was found dead in the woods near a tall oak tree, with blunt-force trauma to the head, neck, and torso, and no eyewitnesses to the death available to investigators. The investigations of the coroner's investigators, including the forensic pathologist, would be critical to whether a subsequent criminal investigation will ensue. If the pathologist (with the assistance of scene investigators) finds signs of foul play, such as signs of other people present at the scene around the time of death, defense wounds, bite marks, or evidence of sexual assault, the manner of death will likely be determined to be a homicide. If, however, the pathologist finds no signs of foul play and evidence gathered at the scene suggests the young woman may have been climbing a tree and fallen out, the manner of death will likely be determined accidental, with no subsequent criminal investigations pursued.

evaluations, and rape investigations; and (3) the statutes that govern the processes for becoming a coroner and the laws that govern the coroner's performance of death investigations.<sup>65</sup> With an understanding of both the Louisiana coroner system in its current form and the laws that govern statewide death investigations, significant problems with the Louisiana scheme become apparent.

### *1. Where the Office of the Coroner Fits in our Governmental Structure*

Louisiana Constitution article V, section 29 establishes the office of the coroner.<sup>66</sup> It states that in each parish, "a coroner shall be elected for a term of 4 years."<sup>67</sup> While the coroners have jurisdiction over their respective parishes only,<sup>68</sup> the position is created by the Louisiana Constitution.<sup>69</sup> The office of the coroner is governed by the state legislature rather than the parish in which a coroner has jurisdiction.<sup>70</sup> Accordingly, the only regulation of coroners comes entirely from state law, although one could also argue that parish voters have some regulatory effect.<sup>71</sup>

### *2. The Role of the Coroner in Louisiana*

The role of the Louisiana coroner is generally three-fold.<sup>72</sup> First, the coroner has the duty to perform death investigations necessary to ascertain cause and manner of death in all cases required by law.<sup>73</sup> This includes cases such as deaths resulting from "violence or accident, or under suspicious circumstances,"<sup>74</sup> or in any death where the coroner believes there is a "reasonable probability that a criminal statute has been violated."<sup>75</sup> Second, the coroner has certain powers to commit people for mental health

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65. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551-1573; LA. CODE CRIM. PROC. ANN. arts. 101-106.

66. LA. CONST. art. V, § 29.

67. *Id.*

68. *Mullins v. State*, 387 So. 2d 1151, 1152 (La. 1980).

69. LA. CONST. art. V, § 29.

70. *Id.*; *Mullins*, 387 So. 2d at 1152-53.

71. LA. CONST. art. V, § 29; *Mullins*, 387 So. 2d at 1152-53.

72. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551-1573 (2002); LA. CODE CRIM. PROC. ANN. arts. 101-106 (2003). *See also* LA. REV. STAT. ANN. § 28:50 (2001).

73. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551-1573; LA. CODE CRIM. PROC. ANN. arts. 101-106.

74. LA. CODE CRIM. PROC. ANN. art. 101.

75. *Id.*

reasons as he or she deems necessary.<sup>76</sup> Third, in certain parishes, the coroner also investigates the medical aspects of rapes.<sup>77</sup> As this Comment focuses primarily on death investigations, it is important to understand the role of the coroners in death investigations and how they interact with police, district attorneys, physicians, families, and witnesses during these practices.

The parish coroner's duty when performing death investigations is to determine the cause and manner of death in any case that falls under his jurisdiction.<sup>78</sup> This generally leads to investigations of deaths occurring under unexplained, violent, accidental, or "suspicious" circumstances.<sup>79</sup> Accurately determining cause and manner of death is crucially important to deaths involving "suspicious" circumstances, as this determination will be a large, if not the largest, factor in determining whether criminal activity has occurred.<sup>80</sup>

Whenever a death occurs under the jurisdiction<sup>81</sup> of the coroner, the office of the coroner, usually through a representative such as a medicolegal investigator, is notified. Upon notification, the investigator will begin acquiring information relating to the circumstances surrounding the death. The investigator (and subsequently the coroner or deputy coroner) will largely base the scope of further investigation on those circumstances.

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76. LA. REV. STAT. ANN. § 28:50.

77. LA. REV. STAT. ANN. § 33:1563(D). In many larger parishes, or in parishes with specialized rape crisis units, the coroner will no longer be responsible to investigate rapes. Telephone Interview with James Falterman, Sr., Coroner, Iberia Parish, in Baton Rouge, La. (Oct. 5, 2007) [hereinafter Falterman Interview]. However, when a parish has no such resources, it is the coroner's duty to see that the rape investigation gets completed. *Id.*

78. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106.

79. LA. REV. STAT. ANN. § 33:1563.

80. *Id.*

81. In order for a coroner to gain jurisdiction, there must first and foremost be a death. *See generally* LA. REV. STAT. ANN. § 33:1563 (supporting the proposition that death gives the coroner jurisdiction). Until then, the coroner has no jurisdiction and any investigations into injuries, illnesses, or other conditions that may eventually contribute to death will initially only be investigated by police and/or medical personnel. When a person has sustained a life threatening injury and is still alive, the forensic investigative process is even less organized. Only police and medical personnel will have the ability to investigate and gather evidence. Furthermore, the likelihood that physical evidence is compromised due to medical treatment during life is great, yet understandable. This is especially true when a victim is presented to an emergency room under life threatening conditions. The well-trained coroner's investigator will be mindful to gather all pertinent information regarding what medical treatment was received and how this medical treatment may have affected subsequent investigations by coroner personnel.

All decisions made by the coroner's personnel at this point in time or shortly thereafter will have a major impact on the investigation. If the coroner decides that the case requires no further investigation, the body may be released to the family for funeral arrangements. If the coroner makes a mistake by releasing a body that should have been subject to further investigation, all evidence will likely be lost due to burial or cremation. Therefore, early investigative decisions made regarding the scope of a coroner's investigation are vitally important and the coroner should be extremely careful and thorough throughout the entire investigative process.

If the coroner decides that a case demands further investigation, the case may require any number of different investigative techniques such as a scene investigation, the gathering of medical records, interviews with witnesses, and possibly retrieval of the body for further investigation in the morgue. The investigations at the morgue will likely include: (1) external examination of the body; (2) photography; (3) collection of physical evidence from the body; (4) the drawing of toxicological specimens such as blood, urine, and vitreous fluid;<sup>82</sup> and (5) if the coroner deems it necessary or if required by law, an autopsy.<sup>83</sup>

The office of the coroner is not the only agency that may respond to the scene of a suspicious or unexplained death. Local or state police will also have jurisdiction. Road officers and Emergency Medical Services (EMS) personnel are usually the first responders to any death scene. Where the scene requires investigations into suspicious or unexplained circumstances, the police detectives and specialized crime scene investigators may also be called in.

As prescribed by law, the coroner is notified of the death (usually by the police or medical personnel) and, when the circumstances require, will report to the scene for the performance of further investigation.<sup>84</sup> In the case of a suspicious or unexplained death, the coroner or his investigator will investigate medical aspects of the body of the decedent and the physical and circumstantial evidence at the scene as it may relate to the cause and manner of death.<sup>85</sup>

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82. Vitreous fluid is "the clear, thick fluid that fills the eyeball." JENTZEN, *supra* note 30, at 353.

83. See generally LA. REV. STAT. ANN. § 33:1563; LA. CODE CRIM. PROC. ANN. arts. 101–102.

84. LA. REV. STAT. ANN. § 33:1562(A).

85. *Id.* § 33:1563; LA. CODE CRIM. PROC. ANN. art. 101.

The police, meanwhile, will generally have primary jurisdiction over evidence at the crime scene itself. When necessary, crime scene detectives will gather physical and circumstantial evidence from the scene. During the investigation, the police and coroner's personnel should be working cooperatively and yet independently in the performance of their duties. Tasks such as photography and interviews with witnesses will usually be performed by both police and coroner's investigators.

While this is the ideal way for a death investigation to proceed, often police and coroner's personnel may come into conflict and not work cooperatively. In the alternative, they may work as one rather than independently, therefore not performing their individualized and separate tasks objectively. While cooperation between the two agencies is expected and encouraged, the parties are governmentally designed to be separate.<sup>86</sup> Therefore, the coroner's office is not required to adhere to police beliefs in the determinations of cause and manner of death.

A most crucial practice of the coroner in death investigations is the performance of an autopsy.<sup>87</sup> This external and internal examination of the body usually encompasses collections of physical evidence from the body, photography of relevant conditions discovered during autopsy, full evisceration and removal of bodily organs, transections of organs, toxicological analysis of bodily fluids and specimens, and microscopic tissue analysis. After gathering this evidence, the physician performing the autopsy determines the cause and manner of death as will be listed on the death certificate and included in the autopsy report. While the cause of death may be anything such as congestive heart failure, toxic effects of multiple drugs, or a gunshot wound to the head, the manner of death is required to be either homicide, suicide, natural, accidental, or undetermined (although in special cases, "under investigation" can also be used).<sup>88</sup>

The coroner's findings of the cause and manner of death are often the determining factor from which the police will arrest and the district attorney may subsequently charge any person deemed to have partaken in criminal activity as related to the death. In

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86. For statutes creating and demonstrating the independence of the coroner as a state officer and the statutes governing the roles of the Louisiana coroners during investigations, see LA. CONST. art. V, § 29, LA. REV. STAT. ANN. §§ 33:1551-1573, and LA. CODE CRIM. PROC. ANN. arts. 101-106.

87. Autopsy is defined in *Black's Law Dictionary* as merely "[a]n examination of a dead body to determine the cause of death, esp[ecially] in a criminal investigation." BLACK'S LAW DICTIONARY 145 (8th ed. 2004).

88. See LA. REV. STAT. ANN. § 33:1563(E), (K)(e).

court, the coroner's determination of cause and manner of death, as well as any subsequent testimony, will likely be important and influential evidence in shaping the outcome of the particular case or trial.<sup>89</sup>

### *3. In Depth Look at Laws Dealing with the Office of the Coroner*

#### *a. Selection of the Parish Coroners*

Louisiana Constitution article V, section 29 creates the office of the coroner by stating:

In each parish a coroner shall be elected for a term of four years. He shall be a licensed physician and possess the other qualifications and perform the duties provided by law. The requirement that he be a licensed physician shall be inapplicable in any parish in which no licensed physician will accept the office.<sup>90</sup>

Therefore, there is no guarantee that the parish coroner will be a physician.<sup>91</sup> If no physician is willing to run for office, then anyone, such as a pastry chef or funeral director,<sup>92</sup> may run for coroner.<sup>93</sup> There are no specific educational requirements other than that the coroner must be a physician when there is one who wishes to run for the office.<sup>94</sup> Also, somewhat of a residency requirement is included. Louisiana Revised Statutes section 33:1554 states that: "The coroner shall be a resident of the parish. However, a licensed physician who is not a resident of the parish but who maintains a full-time medical practice at a principal medical office facility in the parish may qualify for and hold the office."<sup>95</sup> While most parishes have doctors willing to run for coroner, some parishes (especially in rural areas) do not, meaning

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89. LA. REV. STAT. ANN. § 33:1561; LA. CODE CRIM. PROC. ANN. art. 105.

90. LA. CONST. art. V, § 29.

91. *Id.*

92. Allowing a funeral director or funeral home owner to be coroner creates a large conflict of interest. For more information on this dangerous conflict of interest, see *Deadly Conflicts*, *supra* note 48. This conflict of interest that currently goes unregulated in Louisiana has caused many other states to heavily regulate interactions between death investigation personnel and funeral home employees by enacting specific legislation. *Id.* See also LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106 (lacking specific provisions to regulate this conflict of interest in Louisiana).

93. LA. CONST. art. V, § 29. See also Tischler, *supra* note 3, at 558–59.

94. LA. CONST. art. V, § 29.

95. LA. REV. STAT. ANN. § 33:1554.

that the chief medical death investigation official of those parishes will not be a physician.<sup>96</sup>

Louisiana's absence of a requirement that a physician hold the office of coroner is not unique.<sup>97</sup> In fact, many states allow non-physician coroners, regardless of whether a physician qualifies for the office.<sup>98</sup> Although not uncommon to American death investigation, the fact that a physician or a layman rather than a forensic pathologist may head the office of the coroner creates a disconnect with the statutes that govern the Louisiana coroner system.<sup>99</sup> To understand this, one must look to the statutes governing the procedures for determining when and how a coroner is to investigate deaths.<sup>100</sup>

*b. Laws Governing the Coroner in the Performance of Death Investigation*

The Louisiana Code of Criminal Procedure and Louisiana Revised Statutes spell out most aspects governing the inner workings of the Louisiana Coroner System.<sup>101</sup> Especially important to investigations of suspicious deaths are Criminal Procedure articles 101 to 106:<sup>102</sup>

The coroner shall conduct an investigation concerning the manner and cause of any death when informed that death has resulted from violence or accident, or under suspicious circumstances . . . . The coroner may conduct an investigation concerning the medical aspects of any case that may involve medical evidence and in which there is a reasonable probability that a criminal statute has been violated and shall do so when ordered by the court.<sup>103</sup>

This statute, therefore, provides the Louisiana coroner with the charge of determining whether medical evidence leads to a "reasonable probability" that a crime has been committed.<sup>104</sup>

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96. LA. CONST. art. V, § 29; Falterman Interview, *supra* note 77.

97. LA. CONST. art. V, § 29; Tischler, *supra* note 3, at 558-60.

98. Tischler, *supra* note 3, at 558-60.

99. See LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551-1573; LA. CODE CRIM. PROC. ANN. arts. 101-106 (2003).

100. See LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551-1573; LA. CODE CRIM. PROC. ANN. arts. 101-106.

101. LA. REV. STAT. ANN. §§ 33:1551-1573; LA. CODE CRIM. PROC. ANN. arts. 101-106.

102. LA. CODE CRIM. PROC. ANN. arts. 101-106.

103. *Id.* art. 101.

104. *Id.*

The statutes continue by listing the circumstances where an autopsy is *required* to be performed and where an autopsy *may* be performed by the parish coroner and also (quite loosely) governing how the autopsy is to be performed.<sup>105</sup> The Louisiana Code of Criminal Procedure states:

The coroner may perform an autopsy in any death case or cause one to be performed by a competent physician. He shall do so: (1) When there is a reasonable probability that the violation of a criminal statute has contributed to the death; (2) When ordered by the court, which order may be issued ex parte by the court either on its own motion or on application by the district attorney; (3) In all other cases provided by law.<sup>106</sup>

For more in depth instruction, including circumstances that are not necessarily by nature criminal investigations, Louisiana Revised Statutes section 33:1563 spells out three very important situations where the coroner's investigation is required.<sup>107</sup>

First, the statutes lay out all of the situations in which "the coroner shall either view the body or make an investigation into the cause and manner of death."<sup>108</sup> These laws are critical in governing how deaths are investigated by the coroner and are quite similar to most laundry list type statutes regarding what cases the coroner shall investigate.<sup>109</sup>

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105. *Id.* art. 102.

106. *Id.*

107. LA. REV. STAT. ANN. § 33:1563.

108. *Id.* § 33:1563(A). These scenarios are:

1) Suspicious, unexpected, or unusual deaths. 2) Sudden or violent deaths. 3) Deaths due to unknown or obscure causes or in any unusual manner. 4) Bodies found dead. 5) Deaths without an attending physician within thirty six hours prior to the hour of death. 6) Deaths due to suspected suicide or homicide. 7) Deaths in which poison is suspected. 8) Any death from natural causes occurring in a hospital under twenty-four hours admission unless seen by a physician in the last thirty-six hours. 9) Deaths following an injury or accident, either old or recent. 10) Deaths due to drowning, hanging, burns, electrocution, gunshot wounds, stabs or cutting, lightning, starvation, radiation exposure, alcoholism, addiction, tetanus, strangulation, suffocation, or smothering. 11) Deaths due to trauma from whatever cause. 12) Deaths due to criminal means or by casualty. 13) Deaths in prison or while serving a sentence. 14) Deaths due to virulent contagious disease that might be caused by or cause a public hazard, including acquired immune deficiency syndrome.

*Id.*

109. *Id.* See also *infra* Part III.B.



Secondly, section 33:1563 spells out when the coroner "may perform or cause to be performed by a competent physician, an autopsy."<sup>110</sup> This section gives the coroner the ability to have an autopsy performed in any case where he feels one is necessary.<sup>111</sup>

Finally, the statute defines times when the coroner "shall perform or cause to be performed . . . an autopsy."<sup>112</sup> Verbatim from the Code of Criminal Procedure, the coroner shall conduct an autopsy "where there is a reasonable probability that the violation of a criminal statute has contributed to the death."<sup>113</sup> The statutes also require that autopsies be performed "in all cases of infants under the age of one year who die unexpectedly without explanation."<sup>114</sup> In a system that allows non-forensic pathologist and even non-physician death investigative officials to have such great discretion in determining whether further investigation and, most importantly, whether an autopsy is required, the statutes create ample opportunities for mistakes to be made.

Another subtle but vastly important area dealing with governance of the Louisiana coroners involves the laws giving the coroner the ability to hire and work with "expert assistants."<sup>115</sup> Criminal Procedure article 104 states: "The coroner may use expert assistants in the conduct of an investigation, or in the performance of an autopsy."<sup>116</sup> The Louisiana Revised Statutes go into slightly more depth on the issue of what assistants can be appointed by the coroner and what amount of training is needed.<sup>117</sup> Louisiana Revised Statutes section 33:1555 states:

A. Each coroner may appoint one or more deputy or assistant coroners to perform his duties, who need not be residents of the parish. However, any person appointed as a deputy or assistant coroner, who is not a resident of the parish, shall be a licensed physician . . . . The coroner shall be responsible for the acts of his deputy or assistant coroners.

B. The coroner may appoint any necessary secretaries, stenographers, clerks, technicians, investigators, official photographers, or other helpers.<sup>118</sup>

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110. LA. REV. STAT. ANN. § 33:1563(B)(1).

111. *Id.*

112. *Id.*

113. *Id.*; LA. CODE CRIM. PROC. ANN. art. 102 (2003).

114. LA. REV. STAT. ANN. § 33:1563(C)(1)(a).

115. *Id.* § 33:1555; LA. CODE CRIM. PROC. ANN. art. 104.

116. LA. CODE CRIM. PROC. ANN. art. 104.

117. LA. REV. STAT. ANN. § 33:1555.

118. *Id.*

As previously mentioned, all coroners' offices must employ "expert assistants" in order to carry out the duties of the office.<sup>119</sup> Assistants such as deputy coroners, forensic pathologists, medicolegal investigators, pathology assistants, and lab technicians are essential to the performance of death investigations. Because the coroner in many instances is not an expert in death investigation, the great discretion given to coroners via appointment power only furthers the chance for improper investigations to take place.<sup>120</sup>

Every stage of a death investigation is critical. At any point, sloppy or careless practices could result in missing information, contamination of evidence, or, most frighteningly, missing evidence of foul play. While a trained investigator is constantly mindful of the delicate nature of preservation of evidence and the discrete nature of certain types of trauma, an untrained or poorly qualified person is less likely to be. The death investigation itself is only as credible and strong as the weakest link in the chain. Therefore, everyone who investigates at different stages, from scene investigators to forensic pathologists, must exercise extreme discipline and care.

Without properly trained investigators performing all phases of investigations, the chances that homicides are "missed"<sup>121</sup> and subsequent burials or cremations destroy evidence are greatly heightened. By having statutes that allow non-experts in death investigation techniques and practices to appoint investigators, all the while not providing any substantive requirements for the qualifications and training needed in order to be a coroner's assistant, the chances that mistakes are made during the death investigation process are multiplied.<sup>122</sup>

#### *4. Important Areas in Death Investigations Not Currently Addressed by the Louisiana Coroner Statutes*

##### *a. Lack of Regulatory Body and Training Requirements*

Perhaps the most troubling gaps in the laws governing Louisiana death investigations are (1) the lack of a regulatory body supervising the coroners, and (2) the lack of mandated training for

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119. *Id.*

120. *Id.*

121. A homicide that goes undiscovered is commonly referred to as a "missed" homicide by those in the field of medicolegal investigation.

122. LA. REV. STAT. ANN. § 33:1555.

coroners and "expert assistants."<sup>123</sup> There is very little supervision of the coroners in performance of their duties as state officers.<sup>124</sup> When the coroner is a physician, he and all deputy coroners are required to be licensed physicians through the Louisiana State Board of Medical Examiners, the same body that regulates all physicians who wish to practice medicine in Louisiana.<sup>125</sup> This is all that is required for a physician to be coroner.<sup>126</sup>

The same striking lack of regulation for coroners is also present for investigators and technicians appointed by the parish coroners.<sup>127</sup> While an autopsy is required to be performed by a "competent physician,"<sup>128</sup> no other statute speaks to the training necessary for investigators, clerks, pathology assistants, etc.<sup>129</sup> Who may be appointed to these positions and what degree of training they need is currently left up to the discretion of the parish coroner.<sup>130</sup> While associations such as the National Association of Medical Examiners (NAME) and the American Board of Medicolegal Death Investigators (ABMDI) list optimal training requirements and standards necessary to be a qualified pathologist or medicolegal investigator, few parallel requirements exist in Louisiana law.<sup>131</sup>

Because there are so few laws regulating the conduct and qualifications of the coroner and his assistants, and because there is no strong regulatory body responsible for regulation enforcement and training of coroner personnel, the Louisiana scheme is deficient. Due to concerns that coroner's personnel may be poorly trained or may act improperly, many other states have created supervisory agencies or bodies for their death investigation

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123. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106.

124. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106.

125. LA. REV. STAT. ANN. § 33:1555.

126. *Id.* § 33:1554.

127. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106.

128. LA. REV. STAT. ANN. § 33:1563(B); LA. CODE CRIM. PROC. ANN. art. 102.

129. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106.

130. LA. REV. STAT. ANN. § 33:1555; LA. CODE CRIM. PROC. ANN. art. 104.

131. LA. CONST. art. V, § 29; LA. REV. STAT. ANN. §§ 33:1551–1573; LA. CODE CRIM. PROC. ANN. arts. 101–106; JENTZEN, *supra* note 30; National Association of Medical Examiners, <http://thename.org/> (last visited Jan. 19, 2009) [hereinafter NAME]; American Board of Medicolegal Death Investigators, <http://www.slu.edu/organizations/abmdi/> (last visited Jan. 19, 2009).

systems.<sup>132</sup> Because Louisiana has no strong regulatory body, however, problems such as those that arose during the McCormick scandal, where a *forensic pathologist* acted improperly, currently go unregulated by the Louisiana system.<sup>133</sup>

*b. Laws That Limit the Discretion of the Coroner in Determining Whether or Not to Perform an Autopsy*

The laws that determine when an autopsy must be performed are critical to the accurate determination of whether homicides may or may not have occurred. Currently, the Louisiana Revised Statutes only require that “investigation” occur in most unnatural, suspicious, and unexplained deaths.<sup>134</sup> Fourteen common situations requiring investigation are enumerated in Louisiana Revised Statutes section 33:1563(A).<sup>135</sup> While the coroner is only required to investigate these types of deaths, he is allowed to perform or “cause to be performed by a competent physician an autopsy in any case in his discretion.”<sup>136</sup>

While in most of the above enumerated situations, a well trained coroner would require that an autopsy be performed, and while the district attorney would likely make a motion to the court for an autopsy to be performed in any case where the district attorney or police were aware that a homicide may have occurred, certain areas of section 1563(A) should require a full autopsy.<sup>137</sup> Certain deaths that qualify as “suspicious, unexpected, or unusual,”<sup>138</sup> such as apparent drug overdoses, where only a full autopsy can conclusively rule out foul play, should require an autopsy in order to accurately determine the cause and manner of death.<sup>139</sup> Because homicides such as manual strangulations are

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132. For examples of three different death investigation systems, each of which have some form of supervisory body, see *infra* Part III.B.

133. Hayes Testimony, *supra* note 13.

134. LA. REV. STAT. ANN. § 33:1563. See also LA. CODE CRIM. PROC. ANN. art. 101.

135. See LA. REV. STAT. ANN. § 33:1563(A).

136. *Id.* § 33:1563(B).

137. See *id.* § 33:1563(A).

138. See *id.* § 33:1563(A)(1).

139. See *id.* § 33:1563(A); NAT'L ASS'N OF MED. EXAMINERS, FORENSIC AUTOPSY PERFORMANCE STANDARDS, [http://thename.org/index.php?option=com\\_docman&task=doc\\_details&gid=18&Itemid=26](http://thename.org/index.php?option=com_docman&task=doc_details&gid=18&Itemid=26) [hereinafter NAME STANDARDS]. Imagine for instance that a subject is found dead in what appears to be an accidental overdose. Although physical evidence of trauma may not be readily apparent, signs of manual strangulation can be as subtle as petichial hemorrhaging seen only in the eyes or sometimes may be completely non-apparent externally. If only toxicological testing coupled with an external examination is performed,

only detectable upon internal examination of the body, the number of cases where an autopsy is required to be performed should be greatly expanded to cover a greater number of specific situations.<sup>140</sup>

The National Association of Medical Examiners has created a list of circumstances where the "forensic pathologist shall perform a forensic autopsy."<sup>141</sup> The list states that an autopsy shall be performed when:

the death is known or suspected to have been caused by apparent criminal violence; the death is unexpected and unexplained in an infant or child; the death is associated with police action; the death is apparently nonnatural and in custody of a local, state, or federal institution; the death is due to acute workplace injury; the death is caused by apparent electrocution; the death is by apparent intoxication by alcohol, drugs, or poison; the death is caused by unwitnessed or suspected drowning; the body is unidentified and the autopsy may aid in identification; the body is skeletonized; the body is charred; the forensic pathologist deems a forensic autopsy is necessary to determine cause or manner of death or collect evidence.<sup>142</sup>

Although ideally, all situations requiring autopsy as determined by the NAME standards should be encompassed in Louisiana law, certain funding and other legal issues make this, under the current legislative structure, unlikely to occur.<sup>143</sup>

### *B. Comparative Analysis of Louisiana Coroner Laws with Other Jurisdictions*

As previously mentioned, methods employed for death investigation throughout the United States greatly lack uniformity.<sup>144</sup> While many jurisdictions still use coroner systems, some states have switched to medical examiner systems.<sup>145</sup> Other

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signs of manual strangulation not visible externally such as internal hemorrhaging found near the throat muscles or a broken hyoid bone only discoverable via internal examination by performance of a full autopsy could be missed.

140. See generally LA. REV. STAT. ANN. § 33:1563(A); NAME STANDARDS, *supra* note 139. See also JENTZEN, *supra* note 30.

141. NAME STANDARDS, *supra* note 139.

142. *Id.*

143. *Id.*; Falterman Interview, *supra* note 77.

144. Tischler, *supra* note 3.

145. *Id.*

states have medical examiner systems in heavily populated counties while still having county coroners in the more rural areas.<sup>146</sup> Whatever the system employed, the laws and supervisory bodies governing death investigations in the United States are unique to each state.<sup>147</sup> Mississippi, Alabama, and Florida each have very different systems.<sup>148</sup> In order to better understand the variations between Louisiana and other jurisdictions and to better understand how the most proficient systems operate, examining the basic structure and regulation of Mississippi, Alabama, and Florida death investigation systems adds significant perspective.<sup>149</sup>

### *1. The Mississippi Death Investigation System*

The Mississippi death investigation system is a “medical examiner” system by name only.<sup>150</sup> Mississippi legislation recently replaced the title “coroner” with the title “medical examiner” and “medical examiner investigator.”<sup>151</sup> Although the name change may at first glance be significant, no true medical examiner system was established.<sup>152</sup> Mississippi’s death investigation system is based on a hierarchal scheme.<sup>153</sup> The highest office, performing administrative work and running the training course for county investigative personnel, is the State Board of Medical Examiners.<sup>154</sup> They work with the Mississippi Crime Lab to train death investigative personnel in Mississippi.<sup>155</sup> Members on the Board of Medical Examiners are required to be pathologists and are appointed to their positions by the Commissioner of Public

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146. *Id.*

147. *Id.*

148. ALA. CODE §§ 11-5-1–11-5-36 (1989); *id.* §§ 15-4-1–15-4-11 (1995); *id.* §§ 36-18-1–36-18-55 (2001); FLA. STAT. ANN. §§ 406.02–406.61 (West 2002); MISS. CODE ANN. §§ 19-21-101–19-21-109 (West 1999); *id.* §§ 41-61-51–41-61-79 (West 2007).

149. ALA. CODE §§ 11-5-1–11-5-36, 15-4-1–15-4-11, 36-18-1–36-18-55; FLA. STAT. ANN. §§ 406.02–406.61; MISS. CODE §§ 19-21-101–19-21-109; *id.* §§ 41-61-51–41-61-79 (West 2007).

150. MISS. CODE ANN. §§ 19-21-101–19-21-109, 41-61-51–41-61-79; Telephone Interview with Stephanie Baskin, Forensic Scientist, Miss. State Med. Examiner’s Office, in Baton Rouge, La. (Sept. 19, 2007) [hereinafter Baskin Interview].

151. MISS. CODE ANN. §§ 19-21-101–19-21-109, 41-61-51–41-61-79. This name change occurs upon completion of a mandated training course. *Id.* §§ 19-21-105, 41-61-57(2).

152. *See id.* §§ 19-21-101–19-21-109, 41-61-51–41-61-79.

153. *Id.*

154. *Id.* §§ 41-61-51–41-61-79; Baskin Interview, *supra* note 150.

155. MISS. CODE ANN. § 19-21-105; Baskin Interview, *supra* note 150.

Safety.<sup>156</sup> In each county, there is an elected official who oversees medicolegal investigations.<sup>157</sup> What was called a coroner at the county level is now called either a county "medical examiner" or a county "medical examiner investigator."<sup>158</sup> The "medical examiner" title is given to any elected county official who is a physician.<sup>159</sup> The "medical examiner investigator" title is given to an elected county official who is not a physician.<sup>160</sup> Each county will have either a "medical examiner" or a "medical examiner investigator" but will not have both.<sup>161</sup>

Mississippi investigative personnel are subject to several training requirements through the Mississippi Crime Laboratory.<sup>162</sup> County "medical examiners" and "medical examiner investigators" must complete training requirements through the Death Investigation Training School.<sup>163</sup> They also must complete death investigation testing once every four years.<sup>164</sup> Additionally, they are required to attend twenty-four hours of continuing education per year.<sup>165</sup>

## 2. The Alabama Death Investigation System

Alabama currently employs a hybrid death investigation system consisting of some aspects from both the medical examiner and coroner systems.<sup>166</sup> In Alabama's hierarchal scheme, a State Medical Examiner is appointed by the Director of the Department of Forensic Sciences.<sup>167</sup> The State Medical Examiner must be a board certified forensic pathologist licensed to practice medicine in Alabama.<sup>168</sup> This officer appoints "medical examiners" who run the state medical labs.<sup>169</sup> The medical examiners are required to be

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156. See MISS. CODE ANN. § 41-61-55.

157. See *id.* §§ 41-61-51–41-61-79.

158. See *id.* §§ 19-21-103–19-21-105; 41-61-51–41-61-79.

159. See *id.* § 41-61-57.

160. *Id.*

161. *Id.*; Baskin Interview, *supra* note 150.

162. MISS. CODE ANN. § 41-61-57(5).

163. *Id.*

164. *Id.*

165. *Id.*

166. ALA. CODE §§ 11-5-1–11-5-36 (1989); *id.* §§ 15-4-1–15-4-11 (1995); *id.* §§ 36-18-1–36-18-55 (2001); Telephone Interview with Dr. Stephen Boudreau, Director, Ala. Reg'l Med. Lab., Ala. Dep't of Forensic Sciences, in Baton Rouge, La. (Sept. 20, 2007) [hereinafter Boudreau Interview].

167. Boudreau Interview, *supra* note 166.

168. *Id.*

169. *Id.*

pathologists.<sup>170</sup> The medical labs perform all governmentally ordered autopsies for the counties.<sup>171</sup> At the county investigation level, coroners are elected.<sup>172</sup> It is not required that they be medical doctors.<sup>173</sup> When there is an “unlawful, suspicious, or unnatural death” that calls for a forensic autopsy, the body is sent to one of the regional medical labs run by the state medical examiners where an autopsy is then performed.<sup>174</sup> Interestingly, while the coroner is in charge of conducting the medicolegal investigation, the county decision to send a body to a regional laboratory for an autopsy is usually made by the district attorney after consultation with the coroner.<sup>175</sup>

The training of county coroners and assistants is prescribed by the Alabama Coroner’s Training Commission.<sup>176</sup> The county coroners can be suspended by the Governor if they fail to complete the prescribed training.<sup>177</sup>

### 3. *The Florida Death Investigation System*

Perhaps the most different system for purposes of comparison with Louisiana is the Florida medical examiner system.<sup>178</sup> A most important and unique aspect of the Florida system is the Medical Examiner’s Commission, which sits atop Florida’s hierarchal scheme.<sup>179</sup> The Medical Examiner’s Commission is a body appointed by the governor that consists of two active district medical examiners, one funeral director, one state attorney, one public defender, one sheriff, one county commissioner, the Attorney General or his designated representative, and the State Secretary of Health or his designated representative.<sup>180</sup> By mandating that so many different relevant parties have a crucial role in the death investigation system, Florida, at least in theory,

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170. *Id.*

171. *Id.*

172. ALA. CODE § 11-5-1.

173. *See id.* § 11-5-33.

174. *See id.* § 36-18-2. *See also* Boudreau Interview, *supra* note 166; Telephone Interview with Robert Preachers, Coroner, Coffee County, Ala., in Baton Rouge, La. (Nov. 6, 2007) [hereinafter Preachers Interview].

175. ALA. CODE § 36-18-2; Boudreau Interview, *supra* note 166; Preachers Interview, *supra* note 174.

176. ALA. CODE §§ 11-5-31–11-5-36.

177. *Id.*

178. *See* FLA. STAT. ANN. §§ 406.02–406.61 (West 2002).

179. *Id.*

180. *Id.* § 406.02.



creates a balanced and interested death investigation body at the top of its medical examiner's hierarchy.<sup>181</sup>

A critical role of the Medical Examiner's Commission is the nomination of district medical examiner candidates and re-appointment of district medical examiners after a term has been fulfilled.<sup>182</sup> The Florida medical examiner system divides the state into districts.<sup>183</sup> These districts are created based on population size and therefore may encompass multiple counties.<sup>184</sup> For each district, a district medical examiner will be appointed by the governor based on an applicant pool nominated by the Medical Examiner's Commission.<sup>185</sup> Each district medical examiner must be a board certified pathologist.<sup>186</sup> The district medical examiner then appoints different physicians as associate medical examiners as is necessary for the performance of duties in the respective district.<sup>187</sup>

Regulation of the district medical examiners and other inner office staff is provided by the Medical Examiner's Commission.<sup>188</sup> Strict rules and regulations regarding character, fitness, and training must be adhered to in order to hold office.<sup>189</sup> The district medical examiners are appointed for a period of three years, after which they may be reappointed or let go.<sup>190</sup> Florida, therefore, closely regulates the actions of its investigative officers.<sup>191</sup>

By appointing forensic pathologists in each district and heavily regulating these officers, Florida attempts to make sure that the chief investigative officers for each district are qualified and highly competent to oversee multi-county death investigations as well as make important decisions as to the scope of investigation and to the appointment of investigative assistants.<sup>192</sup> Florida, like most other states, reserves in many cases the decision on whether or not to conduct an autopsy to the district medical examiners.<sup>193</sup> Because pathologists are appointed to head each medical examiner district, however, Florida is far better equipped to leave this important decision to the discretion of the chief district officer.<sup>194</sup> Also,

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181. *Id.*

182. *Id.* § 406.06.

183. *Id.* § 406.05.

184. *Id.*

185. *Id.* § 406.06.

186. *Id.*

187. *Id.* § 406.06(2).

188. *Id.* §§ 406.02-406.075.

189. *Id.*

190. *Id.* § 406.02.

191. *See id.* §§ 406.02-406.075.

192. *See id.*

193. *Id.* § 406.11; Tischler, *supra* note 3, at 559-60.

194. FLA. STAT. ANN. §§ 406.06, 406.11.

because a qualified medical examiner is better trained in medicolegal investigation practices, the district medical examiners are better fit to appoint and instruct assistants, such as other investigators and other physicians who help in the performance of investigations.<sup>195</sup>

### *C. Suggestions for Improving the Louisiana Coroner System*

#### *1. A Move to a Medical Examiner System Similar to the Florida Scheme Would Be Beneficial*

If there were to be few or no changes made to the specific statutes governing (1) whether an autopsy should be performed, and (2) the ability of the chief parish death investigation official to appoint necessary assistants, then a move to a district medical examiner system similar to that employed by Florida would be most beneficial to Louisiana. The main reason the current Louisiana system breaks down is not the fact that the discretion to appoint assistants and investigate cases in certain ways is left to the discretion of the coroner; it is that many of the coroners are not properly trained in pathology.

While a few Louisiana coroners are either pathologists or physicians who, subsequent to their becoming coroner, obtained proper pathology training and national certification, many of the Louisiana coroners have little to no specialized training in the area.<sup>196</sup> Therefore, many coroners are ill-equipped to make determinations of (1) whether an autopsy should be performed, and (2) who is qualified to be appointed as a deputy coroner, investigator, or other assistant. Accordingly, many Louisiana coroners are left to make decisions which, even though they may have the best intentions, their lack of training leaves them ill-equipped to make. If, however, similar to Florida, parishes were grouped together based on population and size in order to create districts, each of which was run by a pathologist, the discretion left to the chief officer to make decisions regarding the scope of investigations and the qualification and training of assistants would be more appropriate.

While the creation of a system similar to Florida's would be expensive, requiring a complete overhaul of the Louisiana system,

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195. *Id.* §§ 406.02–406.11.

196. For a list of Louisiana coroners and pathologists who are members of the National Association of Medical Examiners, see Nat'l Ass'n of Med. Examiners, Member Roster, [http://thename.org/index.php?option=com\\_docman&task=cat\\_view&gid=67&Itemid=26](http://thename.org/index.php?option=com_docman&task=cat_view&gid=67&Itemid=26) (last visited Jan. 23, 2009).

if based on a district-wide basis, the number of chief officials necessary for operation of the state system would actually be reduced. Additionally, because many rural parishes currently have problems with funding and attracting physicians to run for coroner, a consolidation based on districts would be ideal. Though the current residency requirement would be superseded, there is no strong reason to require residency in order to investigate parish-wide deaths. As there are only a limited number of trained pathologists in the United States, it would be unreasonable to believe that one could accompany each parish in Louisiana.<sup>197</sup> If, however, the breakdown occurred by multiple parishes forming districts, the ability to find trained pathologists to head each district might be more realistic. Furthermore, the trained pathologist is more likely than an elected coroner to appoint qualified assistants. While the sacrifice of public trust may at first glance occur (due to taking away the privilege to elect a coroner), creating a regulatory body that either appoints or nominates these officials for appointments, similar to the Florida system, would help to create accountability on the part of those charged with making appointments.

A governing body similar to the Florida Medical Examiner's Commission is also an important component. Whether or not the governor would appoint officials as occurs in Florida, without input from a commission composed of interested parties similar to Florida's commission, it is doubtful that changes to the Louisiana system would have the desired effects.

Finally, for there to be any major constructive changes to the Louisiana system, the input of certain current Louisiana coroners would also be necessary. Such a large change to the current Louisiana coroner system would be sure to face harsh opposition from the current coroners. As addressed throughout this Comment, although many Louisiana coroners do not have the training necessary to adequately perform their role as chief death investigation officials, some Louisiana coroners are highly qualified.<sup>198</sup>

Any current coroner with specialized training in pathology should have the knowledge necessary to properly analyze the current system and should therefore be heavily involved in any reform action.<sup>199</sup> Their first hand perspective is invaluable, as

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197. See *id.* for a sampling by state of the number of NAME members of various caliber.

198. See *id.* for a list of Louisiana death investigators who are members of NAME.

199. *Id.*

many of them have been able to perform their jobs with a high level of competence and effectiveness, all the while working in a more challenging environment than would otherwise be encountered in many other states. Furthermore, without overwhelming support from at least some of the current coroners, it is unlikely that any meaningful changes to the current system would be made by the legislature.

*2. If No Medical Examiner System Were to be Employed, the Revised Statutes Should Be Updated*

If no transition to a medical examiner system could be made, the current statutes should be reformed in order to lessen pervasive problems with the current scheme. Three major areas should be addressed. First, it should be required that only physicians can run for and hold the office of coroner. While some parishes do not have physicians that will qualify, eradicating the unnecessary residency requirement would allow more physician candidates to qualify. Second, reforms to the Louisiana statutes governing the extent and processes by which deaths are investigated, including expanding the number of cases where an autopsy must be performed in order to conform more closely to the NAME standards, must be accomplished.<sup>200</sup> This will curtail some of the current discretion given to all coroners, including those not qualified to exercise such discretion as to the scope of a death investigation. Third, the training requirements and regulation procedures for the state coroners should be heightened, similar to those now employed by Mississippi, Alabama, and Florida.<sup>201</sup> By requiring that coroners obtain specified death investigation training, the chances that coroners will mishandle death investigations, either through poorly choosing which cases should be autopsied or poorly choosing who is most qualified to be appointed as an assistant, will be lessened.

*3. Better Funding*

Perhaps nothing hinders the function of the current coroner system more than the problem of poor funding.<sup>202</sup> Poor funding is

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200. LA. REV. STAT. ANN. § 33:1563 (2002); LA. CODE CRIM. PROC. ANN. art. 102 (2003); NAME STANDARDS, *supra* note 139.

201. *See supra* Part III.B.

202. Falterman Interview, *supra* note 77. *See also* Tischler, *supra* note 3, at 558 (discussing poor funding that affects death investigations in the United States as a whole).

especially problematic in smaller, more rural parishes.<sup>203</sup> Funding problems affect all coroners' offices in a number of different ways. Perhaps the two greatest problems caused by poor funding are (1) it limits the scope of death investigations, and (2) it creates the inability to attract qualified personnel.

While there may be the occasional circumstance where the coroner of a certain parish makes a mistake due to poor training or acts negligently or in bad faith for a certain self-serving reason, most coroners and coroner personnel are simply doing the best they can to perform their duties with what limited resources they have. It is totally unrealistic, given the poor funding in many parish offices, that the NAME standards could be followed fully for all death investigations.<sup>204</sup> Autopsies and other postmortem examination procedures are expensive. Most offices do not have the resources available to conduct extensive investigation in all cases that require such measures. Therefore, in many parishes, the reality of finances means that only the most obviously suspicious and unexplainable of the deaths investigated by coroners are selected for autopsy. Those which seem to have enough evidence to eliminate the "reasonable probability"<sup>205</sup> of foul play may often not be subject to a full autopsy due simply to a lack of resources. Therefore, a mistake by a coroner's office resulting in a "missed" homicide or an improper conclusion as to cause and manner of death is not usually due to a bad faith or negligent effort on the part of unqualified personnel, but is rather a result of the poor funding reality that causes coroners to heavily screen which cases will be autopsied.

Lack of funding also has a drastic effect on the ability of certain parishes to obtain qualified personnel. First, it is difficult for many parishes to get qualified physicians to run for the office of coroner. Second, coroners have difficulty in recruiting and appointing qualified personnel, such as deputy coroners and investigators. In reality, the coroner and his personnel are public servants who likely have made great financial and personal sacrifices in order to hold their offices and perform their duties. As emotional costs of the job are high, the ability to recruit qualified personnel for investigative positions is naturally quite difficult. Most coroner personnel work long hours, often on an on-call basis, daily encountering emotionally trying situations such as gruesome deaths, interviewing and interacting with distressed family members of a decedent, and making death notifications. These

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203. Falterman Interview, *supra* note 77.

204. NAME STANDARDS, *supra* note 139.

205. LA. CODE CRIM. PROC. ANN. art. 102.

realities of the job make it harder to attract and retain qualified and experienced personnel. Accordingly, in order to ensure that Louisiana has a chance at recruiting and retaining qualified personnel, salaries must be increased.

#### 4. *Creation of a Higher Regulatory Body*

Lack of funding is obviously a big part of the problem. However, better funding is not likely to have its desired effect without other measures simultaneously enacted. It is important to remember that no amount of money could have prevented the McCormick scandal.<sup>206</sup> There, a forensic pathologist in a relatively well funded office blatantly broke the law.<sup>207</sup> This could have been either prevented or discovered and stopped much sooner had a state regulatory body been supervising McCormick's actions.<sup>208</sup> However, since there was no effective regulatory body supervising his office, McCormick's actions continued unregulated for what appeared to be seven or more years.<sup>209</sup> Without effective higher governmental regulation, nothing can prevent certain officers (no matter what their education) from blatantly failing to perform their statutorily prescribed duties. Better regulation, therefore, through the creation of a state medical examiner's office or commission, or regulation through a board or government agency charged with administrative and supervisory duties throughout the statewide death investigation system, is necessary in order to ensure that better funding and better laws have the desired effect.

#### 5. *Abolish the Mental Health and Rape Duties*

If Louisiana required that specialists in pathology run parish-wide offices, logic would suggest that death investigations would be more competently performed. There is another side to the story, however, because coroners in the current Louisiana system handle mental health commitments and, in some parishes, rapes as well.<sup>210</sup>

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206. Hayes Testimony, *supra* note 13.

207. *Id.*

208. *Id.*

209. *Id.*

210. LA. REV. STAT. ANN. § 28:50 (2001); *id.* § 33:1563(F) (2002). Through an Order of Protective Custody (OPC), a coroner can require that the police pick up a person from their home and transfer them to either an emergency room or a mental health hospital against their will for a mental health evaluation. *See id.* § 28:50. Also, through the coroner's emergency certificate (CEC), coroners may extend the treatment time of someone who was receiving inpatient treatment by a mental health care provider at the time of evaluation. *Id.*

Because coroners possess the power to commit people against their will for mental health reasons and because many other physicians who possess similar powers refer those seeking commitments to the coroner, the Louisiana coroners spend ample time handling these evaluations.<sup>211</sup> Also, coroners in many parishes handle investigation of alleged rapes.<sup>212</sup> Therefore, the Louisiana coroners in many parishes are responsible for investigations and medical evaluations for two categories of the living.<sup>213</sup> While some of the larger parishes split their offices into divisions, with deputy coroners specializing in a specific area, many of the smaller parishes simply do not have the resources and therefore must perform multiple actions with less specialized personnel.<sup>214</sup> If the coroner must handle different specialized medical duties over both the living and the dead, one could actually argue that a forensic pathologist trained specifically in death investigations would not be nearly as qualified to handle mental health and rape evaluations as certain other types of physicians.

Almost all of the issues raised in this Comment regarding the lack of qualified personnel necessary in order to perform competent death investigations can also be raised in the duties of mental health evaluations and rape investigations. Clearly, each of these areas should require specialized expertise. There is no apparent reason why the citizens of the state would not be better served by three separate agencies, each of which would be better able to specialize in their respective fields. By delegating these separate roles to three individual and specialized offices, coroners could focus more time and resources on ensuring that death investigations are competently executed.

#### *D. Is There Reform on the Horizon?*

After problems encountered during Hurricane Katrina and the fallout that resulted from the scandal involving Dr. McCormick, legislators have attempted to rectify certain problems in the current Louisiana coroner system.<sup>215</sup> Funding has been approved and plans are progressing for the construction of a forensic center in North Louisiana that will provide autopsy and other death investigation

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211. *See id.*

212. *Id.* § 33:1563(F).

213. *Id.* §§ 28:50, 33:1563(F).

214. Falterman Interview, *supra* note 77.

215. S.B. 571, 2006 Reg. Sess. (La. 2006), available at <http://www.legis.state.la.us/>; Welborne, *supra* note 15, at 1A; Editorial, *Justice, Science Don't Come Cheap*, THE TIMES (Shreveport, La.), Mar. 10, 2007, at 11A [hereinafter *Don't Come Cheap*].

services to certain North Louisiana parishes.<sup>216</sup> Also, in 2006, a bill was proposed that would have created the position of "State Medical Examiner," a position which would have been charged with regulating the current Louisiana coroners and promoting coordination and cooperation between coroners during emergencies and mass disasters.<sup>217</sup> Although both efforts suggest that attempts to improve the current coroner system are being made, challenges and problems facing both of these projects have raised serious questions as to whether either will be successful.<sup>218</sup>

### *1. The North Louisiana Forensic Center*

In the aftermath of the McCormick scandal, many North Louisiana parishes that previously used McCormick for autopsy services were forced to find other places in which to obtain autopsies.<sup>219</sup> Some parishes were forced to transport bodies to distant locations such as Arkansas and Mississippi, in many cases significantly raising expenses.<sup>220</sup> In response to these problems, the legislature has approved plans to build a large forensic center on property donated by the LSU Department of Health and Hospitals.<sup>221</sup> This center is intended to be the central location where twenty-nine parishes in North Louisiana will obtain autopsy services.<sup>222</sup> Coroners, as independent state officers, however, have the ability to choose where they send their respective autopsies.<sup>223</sup> Therefore, it is unclear whether many coroners in the twenty-nine parish area will choose to outsource to this facility.<sup>224</sup> Until this facility becomes fully operational, it will be difficult to assess whether it will have a positive effect on death investigation practices in North Louisiana.

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216. Welborne, *supra* note 15, at 1A; *Don't Come Cheap*, *supra* note 215.

217. S.B. 571, 2006 Reg. Sess.

218. *See id.*

219. Hayes Testimony, *supra* note 13; Welborne, *supra* note 15, at 1A.

220. Welborne, *supra* note 15, at 1A.

221. *Id.*

222. *Id.*

223. LA. CONST. art. V, § 29; Telephone Interview with Patrick Wojtkiewicz, Director, North Louisiana Crime Lab, in Baton Rouge, La. (Oct. 29, 2007) [hereinafter Wojtkiewicz Interview].

224. LA. CONST. art. V, § 29; Wojtkiewicz Interview, *supra* note 223.



## 2. Senate Bill No. 571?<sup>225</sup>

In 2006, Senate Bill No. 571 was proposed in an attempt to create the position of "State Medical Examiner."<sup>226</sup> This position would have regulated some of the coroners' actions and assisted coroners with coordination during emergencies and mass disasters.<sup>227</sup> Although the majority of language in the proposal was aimed at coordination of death investigation practices during emergency situations such as hurricanes, it also included a proposal that would have granted the State Medical Examiner the ability to create a "credentialing process for death investigators based on national standards."<sup>228</sup> Unlike the Florida Medical Examiner system, however, the bill contained no plans to include interested parties such as current coroners, sheriffs, district attorneys, and funeral directors in some sort of commission.<sup>229</sup> Typical of a poorly thought out, piecemeal attempt at reform, the bill instead intended only to create a position for one governmental officer who would have been granted authority over the current coroners in certain enumerated scenarios.<sup>230</sup> After this bill was referred to the Senate Committee on Health and Welfare, it appears that it has failed to receive consideration and in all likelihood has died in the Senate.<sup>231</sup>

## IV. CONCLUSION

Scandals such as the one which occurred in Caddo Parish are a reminder to the public that the Louisiana death investigation system is far from infallible, plagued by outdated laws and no legally prescribed governmental supervision of the parish coroners. Because death investigation practices have such a dramatic effect on our public welfare and civil liberties, Louisiana should demand that its methods for investigating suspicious deaths be highly competent and performed by qualified individuals. The Louisiana

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225. S.B. 571, 2006 Reg. Sess. (La. 2006), available at <http://www.legis.state.la.us/>.

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*; FLA. STAT. ANN. § 406.02 (West 2002).

230. S.B. 571, 2006 Reg. Sess. This bill, quite inexcusably, also would have given sole appointment power to the state health officer, who would have needed approval only from the secretary of the Department of Health and Hospitals. *Id.* Relevant interested parties such as coroners, funeral directors, medical personnel, district attorneys, and other law enforcement agencies were to be excluded from the appointment process as well. *Id.*

231. *Id.*

Legislature desperately needs to make major reforms to the current coroner system, which must include: (1) major statutory revisions; (2) some type of higher government mandated supervision of death investigators; and (3) better funding. Until these changes are made, the likelihood that violent deaths will go undiscovered, that individuals will be wrongfully prosecuted for homicides, and that improper answers will be provided to the public and the courts will be far greater than most citizens would ever care to imagine.

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